



NEW PATIENT INTAKE FORM

Today's Date _____ / _____ / _____

Name: _____ SS#: _____ Birthdate: _____
 Marital Status: _____ Occupation: _____ Age: _____
 Address: _____ City, State, Zip _____
 Home phone: _____ Work: _____ Cell: _____
 Emergency Contacts Name and Phone: _____
 Referred by: _____
 Reason for visit today: _____ Have you had acupuncture before? Yes No Chinese herbal medicine? Yes No
 How long have you had this condition? _____ Does it bother your Sleep Work Other (specify) _____
 Is it getting worse? _____
 What seemed to be the initial cause? _____
 What seems to make it better? _____
 What seems to make it worse? _____
 Are you under the care of a physician now? Yes No If yes, for what? _____
 Physician's name: _____ Physician's Phone: _____

OTHER CONCURRENT THERAPIES

Health Insurance info: _____ Policy #: _____
 Insurance Co. Name: _____ Phone: _____
 Address: _____ City, State, Zip: _____

Medicare Info: _____ Policy #: _____
 Insurance Co. Name: _____ Phone: _____
 Address: _____ City, State, Zip: _____

FAMILY MEDICAL HISTORY

Allergies (list) _____ Arteriosclerosis _____ Cancer (type) _____ Diabetes (type) _____ Seizures _____
 Asthma _____ Heart disease _____ Stroke _____
 Alcoholism _____ Depression _____ High blood pressure _____

YOUR PAST MEDICAL HISTORY

(Check any of the following conditions you currently have, or have had in the past. Please also check if you feel any of the following are a significant part of your medical history).

<input type="checkbox"/> AIDS	<input type="checkbox"/> Diabetes (type) _____	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Surgery (list) _____	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Mumps	_____	<input type="checkbox"/> Typhoid fever
<input type="checkbox"/> Allergies	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Pacemaker (date: _____)	_____	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Goiter	<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Thyroid disorders	<input type="checkbox"/> Venereal disease
<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Gout	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Major trauma	<input type="checkbox"/> Whooping cough
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Polio	<input type="checkbox"/> (Car, fall, etc-list) _____	<input type="checkbox"/> Other (specify) _____
<input type="checkbox"/> Birth trauma	<input type="checkbox"/> Hepatitis (type) _____	<input type="checkbox"/> Rheumatic fever	_____	_____
<input type="checkbox"/> (your own birth)	<input type="checkbox"/> herpes (type) _____	<input type="checkbox"/> Scarlet fever	_____	_____
<input type="checkbox"/> Cancer	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Seizures	_____	_____
<input type="checkbox"/> Chicken pox	<input type="checkbox"/> Measles	<input type="checkbox"/> Stroke	_____	_____

YOUR DIET

Appetite Low High Coffee/Tea Soft drinks/Fruit Juices Protein intake Low High Artificial Sweeteners Sugar Salty foods Thirst for water: # glasses per day:

AVERAGE DAILY MENU

Morning _____	Snack _____	Noon _____	Snack _____	Evening _____	Snack _____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Pharmaceuticals taken in last 2 months: _____

Vitamins taken in last 2 months: _____

PRACTITIONER USE ONLY

YOUR LIFESTYLE

(Check any of the following conditions you currently have, or have had in the past. Please also check if you feel any of the following are a significant part of your medical history).

- | | | | |
|----------------------------------|------------------------------------|---|----------------------------|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Marijuana | <input type="checkbox"/> Stress | Regular Exercise |
| <input type="checkbox"/> Tobacco | <input type="checkbox"/> Drugs | <input type="checkbox"/> Occupational hazards | type _____ Frequency _____ |
| | | | type _____ Frequency _____ |

GENERAL SYMPTOMS

- | | | | | |
|--|--|--|---|--|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Body heaviness | <input type="checkbox"/> Chills | <input type="checkbox"/> Bleed or bruise easily |
| <input type="checkbox"/> Heavy appetite | <input type="checkbox"/> Heavy sleep | <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Peculiar taste (describe) _____ |
| <input type="checkbox"/> Strongly like cold drinks | <input type="checkbox"/> Dream-disturbed sleep | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Sweat easily | _____ |
| <input type="checkbox"/> Strongly like hot drinks | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Muscle cramps | _____ |
| <input type="checkbox"/> Recent weight gain/loss | <input type="checkbox"/> Lack of strength | <input type="checkbox"/> fever | <input type="checkbox"/> Vertigo or dizziness | _____ |

HEAD, EYES, EARS, NOSE, THROAT

- | | | | | |
|--|---|--|---|--------------------------------------|
| <input type="checkbox"/> Glasses (what age: _____) | <input type="checkbox"/> Night blindness | <input type="checkbox"/> Gum problems | <input type="checkbox"/> Recurrent sore throat | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Eye strain | <input type="checkbox"/> Myopia or Presbyopia | <input type="checkbox"/> Sores on lips or tongue | <input type="checkbox"/> Swollen glands | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Eye pain | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Lumps in throat | <input type="checkbox"/> Concussions |
| <input type="checkbox"/> Red eyes | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Excessive saliva | <input type="checkbox"/> Enlarged thyroid | Other head or neck problems _____ |
| <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Teething problems | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Nosebleeds | _____ |
| <input type="checkbox"/> Spots in eyes | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Excessive phlegm | <input type="checkbox"/> Ringing in ears (high or low?) _____ | _____ |
| <input type="checkbox"/> Poor vision | <input type="checkbox"/> TMJ | Color: _____ | <input type="checkbox"/> Poor Hearing | _____ |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Facial pain | | <input type="checkbox"/> Earaches | _____ |

RESPIRATORY

- | | | | | |
|---|---|--------------------------------|-----------------------|--|
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Tight chest | <input type="checkbox"/> Cough | Color of phlegm _____ | <input type="checkbox"/> Coughing up blood |
| When lying down | <input type="checkbox"/> Asthma/wheezing | Wet or dry? _____ | | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Difficulty inhaling/exhaling | Thick or thin? _____ | | |

CARDIOVASCULAR

- | | | | | |
|--|---|---|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Tachycardia | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Fainting | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Irregular heartbeat |

GASTROINTESTINAL

- | | | | | |
|---|--|---|-----------------|--------------------|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Intestinal pain/cramps | Bowel movements | |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Constipation | <input type="checkbox"/> Burning anus | Frequency _____ | Texture/form _____ |
| <input type="checkbox"/> Acid regurgitation | <input type="checkbox"/> Black Stools | <input type="checkbox"/> Rectal pain | Color _____ | Odor _____ |
| <input type="checkbox"/> Gas | <input type="checkbox"/> Bloody stools | <input type="checkbox"/> Anal fissures | | |
| <input type="checkbox"/> Hiccup | <input type="checkbox"/> Hemorrhoid | <input type="checkbox"/> Laxative use | | |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Itchy Anus | What kind? _____ | | |
| <input type="checkbox"/> Bad breath | | How often? _____ | | |

MUSCULOSKELETAL

- | | | | | |
|---|--|-------------------------------------|--|------------------------|
| <input type="checkbox"/> Neck shoulder pain | <input type="checkbox"/> Upper back pain | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Limited range of motion | Other (describe) _____ |
| <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Rib pain | <input type="checkbox"/> Limited use | _____ |

SKIN AND NAILS

- | | | | | |
|--------------------------------------|------------------------------------|------------------------------------|---|-----------------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Eczema | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Changes in hair/skin | Other hair or skin problems _____ |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Itching | <input type="checkbox"/> Fungal infections | _____ |
| <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Acne | <input type="checkbox"/> Hair loss | | _____ |

NEUROPSYCHOLOGICAL

- | | | | | |
|-----------------------------------|--------------------------------------|--|--|-----------------------|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Irritability | <input type="checkbox"/> Considered/ attempted suicide | Other (specify) _____ |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Depression | <input type="checkbox"/> Easily stressed | <input type="checkbox"/> Seeing a therapist | _____ |
| <input type="checkbox"/> Tics | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Abuse survivor | | _____ |

GENITOURINARY

- | | | | | |
|---|---|---|---|--|
| <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Increased libido | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Decreased libido | <input type="checkbox"/> Premature ejaculation |
| <input type="checkbox"/> Urgent urination | <input type="checkbox"/> Incomplete urination | <input type="checkbox"/> Wake to urinate | <input type="checkbox"/> Kidney stone | <input type="checkbox"/> Nocturnal emission |

GYNECOLOGY

- | | | | | |
|---|---|--|---|------------------------------|
| <input type="checkbox"/> Age menses began _____ | <input type="checkbox"/> Duration of flow _____ | <input type="checkbox"/> Vaginal discharge color _____ | <input type="checkbox"/> Breast lumps _____ | Date of last PAP _____ |
| length of cycle (day 1-day 1) _____ | <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Vaginal sores | # pregnancies _____ | Date last period began _____ |
| | <input type="checkbox"/> Painful periods | <input type="checkbox"/> Vaginal odor | # Live births _____ | |
| | <input type="checkbox"/> PMS | <input type="checkbox"/> Clots | # Premature births _____ | |
| | | | Age at menopause _____ | |

OTHER _____